ELPIS PAIN MANAGEMENT CENTER
4122 KEATON CROSSING BLVD.
STE 102
O'FALLON, MISSOURI 63368
PH: 636-329-9077
FAX: 636-329-9076

Authorization for Treatment and/or Financial Responsibility

1. CONSENT

I authorize my physicians, their associates and assistants and Elpis Pain Management Center, its house staff, employees and students to provide the medical care, tests, procedures, drugs, blood or blood products, services and supplies considered advisable by my physician(s). These services may include pathology, radiology, emergency services and other special services ordered by my physician(s). In consenting to treatment, I have not relied on any statements as to results. I further authorize my physician or staff to examine, use, store and/or dispose of in any manner (except for organ donation and/or transplantation) any bones, organs, tissues, fluids or parts removed from my body. In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substances that is capable of transmitting disease and I am unable to timely consult with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to or infectious agents of, hepatitis A, B, and C and HIV.

2. STORAGE AND RELEASE OF INFORMATION

I consent to the electronic storage and transmission of patient health information. I hereby authorize Elpis Pain Management Center and its affiliates, my treating physicians to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records, to the following:

a. the health professionals involved or who will be involved in my care either at Elpis Pain Management Center or following hospitalization;
b. the person or entity responsible or who may be responsible to pay for any or all of my care rendered by Elpis Pain Management Center or on behalf of Elpis Pain Management Center;
c. any governmental or other entity as required by law for purposes of reporting, or for purposes of determining eligibility in government sponsored benefit programs;
d. Elpis Pain Management Center personnel who perform activities that assess or evaluate the health or other services that the clinic or other health professionals may provide, including but not limited to, case management, accreditation surveys, or clinical reviews;
e. the supplier of any blood or blood products which may be administered to me for the purposes of quality control and recipient monitoring; or
f. any continuing care, residential, or long-term care facility, or home health agency for the purpose of providing services for my care.

3. PERSONAL VALUABLES

Elpis provides facilities that may be used for the safekeeping of money, valuables or other personal effects, including but not limited to dentures, eyeglasses or contact lenses, if I choose not to use those facilities, I understand that I assume all responsibility for the loss or damage of any money, valuables or other personal effects during my visit.

4. MEDICARE/TRICARE INSURANCE BENEFITS

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the release of medical or other information to the Medicare Program or its intermediaries or carriers concerning this or a related claim filed by Elpis Pain Management Center. I request that payment of authorized benefits be made on my

behalf. I understand that I am responsible for the Part A and Part B deductible for each year and/or visit, the remaining co-insurance and any other non-covered personal charges. I hereby acknowledge receipt of the Medicare/Tricare letter entitled "An Important Message from Medicare/Tricare." I (or my representative) certifies that I or he/she has read (or if the patient/representative is unable to read has had the form read to him/her) and understand(s) and accept(s) the above and further certifies that I am the patient or am duly authorized on behalf of the patient to execute such an agreement.

5. PHOTOGRAPHS, FILM OR VIDEO TAPE

I consent to and authorize the storage and taking pictures, video and/or electronic images in the course of my visit/procedure/operation for the purpose of medical education or training; provided, however, that my identity may not be revealed by any pictures or descriptive text accompanying any photographs or images.

6. GUARANTEE FOR PAYMENT

In accordance with the above terms and in consideration of the services provided to the above-named patient by Elpis Pain Management Center the undersigned agrees, whether he/she signs as patient or guarantor, to pay the clinic and physicians for all services ordered by the attending physician, the patient and the patient's family. If the requirements for referral, second opinion or pre-certification of care, as outlined by my insurer, benefit plan or other payor, have not been followed, the patient and/or guarantor may in some instances be personally responsible for all charges incurred.

7. ASSIGNMENT OF INSURANCE BENEFITS

In consideration of any and all medical services, care, drugs, supplies, equipment and facilities furnished by Elpis Pain Management Center and all attending physicians, I authorize direct payment to the Elpis Pain Management Center of all insurance benefits applicable to this visit, which are now or which shall become due and payable to me. In addition, I hereby authorize direct payment to the Elpis Pain Management Center of all insurance benefits applicable to medical and/or surgical services rendered by physicians for whom the Elpis Pain Management Center is authorized to charge and bill.

HIPAA - Notice of Privacy Acknowledgment

_____

Initials of patient or person authorized to sign for patient

I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, where, and why my confidential health information may be used or shared. I acknowledge that Hospital, the physicians, the nurses, and other Hospital staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern Hospital operations and responsibilities.

I have also received or have been provided the opportunity to receive the Patient Bill of Right

---

The undersigned certifies that the conditions of admission have been read and are understood. The undersigned is the patient or is duly authorized to act on behalf of the patient to execute these conditions of admission and accept the terms thereof.

_____ _____

Signature of patient or person authorized to consent/Relationship to Patient Date

_____ _____

Witness (authorized staff signature) Date